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ABSTRACT

The North American Council on Adoptable Children (NACAC) released this report in response to recent calls for a return to institutionalized care for children. The response is based on NACAC's long-held position that: (1) every child deserves a family; (2) institutionalization is not an acceptable substitute for a family; and (3) many important, more cost-effective, and humane options to institutionalization have not been tried. The report notes that infants and young children, many with medical complications and physical and mental limitations due to prenatal drug exposure, comprise the fastest growing group of children entering substitute care. It is estimated that 375,000 of the infants born in 1988 had been exposed to drugs before birth. Many successful maternal health and prenatal care programs bring about favorable outcomes for mother and child. These programs offer a variety of options, such as client-oriented scheduling, integration of key services, and inclusion of the family in client services. However, a large and growing number of women do not have access to adequate public health services, prenatal care, or drug treatment. As for the call for a return to orphanages, it is maintained that long-term institutionalization in childhood leads to recurrent problems in later life. It is noted that a return to orphanages would be in clear violation of Public Law 96-272, the federal Adoption Assistance and Child Welfare Act of 1980. Contains 48 references. (LB)

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Research Brief #1

November 1990

CHALLENGES TO CHILD WELFARE:

Countering the Call for a Return to Orphanages

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CHALLENGES TO CHILD WELFARE:

Countering the Call for a Return to Orphanages

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Executive Summary

In recent months, the popular media has included many calls for a return to institutionalized care for children. It has long been the position of the North American Council on Adoptable Children (NACAC) that every child deserves a *family*. Institutionalization is not an acceptable substitute, and many important, more cost effective, and humane options exist that have not yet been vigorously explored. We must work to ensure that public policy does not take the "easy way out" and return to orphanages when more innovative approaches will have a positive and profound impact on the lives of thousands of children.

Consequently, NACAC has released this paper—*Challenges to Child Welfare: Countering the Call for a Return to Orphanages.* Research was conducted by Mary Ford, M.S.W. Among the paper's findings:

- Infants and young children, many with medical complications and physical and mental limitations due to pre-natal drug exposure, comprise the fastest growing group of children entering substitute care today.

- It is estimated that as many as 375,000 infants were born drug-exposed in 1988 (U.S. Select Committee on Children, Youth and Families, 1989a).

- A large and growing number of women do not have access to the public health services, prenatal care, or drug treatment that would ensure more positive outcomes for their pregnancies.

- Many successful maternal health and pre-natal care programs exist that yield favorable outcomes for mother and child. They include components such as tailoring organizational practices to meet the needs of the consumer (i.e. Saturday appointments, assistance with transportation, child care, culturally sensitive or bi-lingual staff); integration of key services, rather than categorical delivery of WIC, family planning services, etc.; and identifying both the client and the client's family as recipients of services to be delivered in the client's neighborhood and home.

- Fifty years of research reconfirms the same findings: long-term institutionalization in childhood leads to recurrent problems in interpersonal relationships, a higher rate of personality disorders, and severe parenting difficulties later in life. Even a small residential facility is ultimately a public institution, and consequently a poor parent.

- More intensive and longer lasting services to children at home are needed to maintain families in times of stress and prevent the need for out-of-home placements.

- Vigorous foster family recruitment should focus on families who are willing to become the child's adoptive family if reunification fails.

- Case management practice should use a two-pronged approach in which reunification and termination of parental rights and adoption are discussed simultaneously with biological parents in order to resolve the question of permanency in a timely manner.

- Both traditional and non-traditional families (e.g. single-parent families, families who receive public assistance, and others) should be recruited and specially trained to care for medically fragile children. Remuneration should be commensurate with the conditions of fostering special needs children and the training it requires.

- A return to orphanages is in clear violation of Public Law 96-272, the federal Adoption Assistance and Child Welfare Act of 1980.

- This nation cannot afford an institutional solution to the exploding population of children in foster care. Both the human and financial costs are totally unacceptable.

Children Targeted for Institutionalization

In the last five years children ages birth to four entered the child welfare system in unprecedented numbers, especially in urban areas. Teenagers with a history of multiple, out-of-home placements continue to rotate through the child welfare system. Children's complex needs make the existing system not only numerically overwhelmed, but hard-pressed to deal with infants and toddlers affected by drugs. To complicate the problem further, universal public health and accessible prenatal programs do not exist—programs which might identify risks early in a woman's pregnancy, do not exist. This seemingly overwhelming situation prompts the call for a return to orphanages.

Given the problem and a legitimate demand for solving it, a careful review of scientific literature and existing programs recommends itself.

Characteristics of Medically Fragile Children

In 1989 the U.S House Select Committee on Children, Youth and Families recognized that infants and young children, many with medical complications and physical and mental limitations, comprise the fastest growing group of children entering substitute care today. Child welfare agencies associate the high incidence of crack use among pregnant and parenting women with an increased need for out-of-home placement of infants and young children. It is estimated that as many as 375,000 infants were born drug-exposed in 1988. In Illinois the number of medically fragile infants requiring out-of-home placement rose 132 percent between 1987 and 1988 (U.S. Select Committee, 1989a). Since 1985, hospitals surveyed in the United States by the Select Committee on Children, Youth and Families report a three-fold increase in the incidence of substance abuse during pregnancy and a reciprocal increase in the number of drug-exposed neonates. (U. S. Select Committee,1989a).

Drug-exposed or drug-addicted infants under one year of age often demonstrate an inability to communicate hunger, fatigue, and discomfort cues. Infants fail to regulate their own states of arousal in response to environmental stimuli; they may appear sleepy during activity or hyper-alert during quiet time. Infants unable to maintain an alert state frustrate their caregivers by not responding to nurturance, feeding, and sleeping routines. Drowsiness, alertness, crying and agitation occur unexpectedly and tend to diminish infant interaction with their caregiver and surroundings. The drug-

exposed or drug-addicted infant may feed poorly, suck in a disorganized manner, and regurgitate frequently. The caregiver is further frustrated when he or she attempts to comfort the inconsolable infant who is irritable, hypersensitive to sound, emits piercing cries, and exhibits muscle rigidity (Howard & Kropenske, 1990; Chasnoff, 1988).

While cocaine and crack are the current scourge of many vulnerable pregnant women and children today, heroin and alcohol abuse have long-term effects as well. Finnegan (1986) reports that prenatal exposure to opiates damages children's fine motor coordination, attention span, frustration tolerance, and sleep patterns among those studied up to age five. Hanson et al (1978) report that fetal alcohol syndrome (FAS) occurs in 1-3/1000 live births. FAS retards prenatal and postnatal growth, causes central nervous system deficits and facial feature anomalies (Jessup & Green, 1987). The long-term effects of FAS mean that school-age victims will need intervention to monitor hyperactivity, inattentiveness and impulsive behavior, and they may require special education and medical care in severe cases. While FAS children may make psychological and cognitive gains, they tend to have persistent academic difficulties (Streissguth, Clarren & Jones, 1985; Spohr, 1987). Streissguth et al (1986) discovered prenatal alcohol exposure was significantly related to attentional decrements, slower reaction time, and distractibility in 475 seven and a half year old children.

Keith et al (1989) note that relative to opiate addiction, cocaine addiction during pregnancy threatens more harm for both mother and child. In order to discern developmental differences, toddlers born drug-addicted or exposed to drugs (cocaine and other substances) were compared to a similar sample of high-risk preterm toddlers not exposed to drugs (Howard et al, 1989). The study found that toddlers who were born drug exposed exhibited a higher rate of disorganized behavior compared to the group of toddlers who were not born drug-exposed. Drug-exposed toddlers engaged in a higher number of disorganized play events characterized by scattering and batting toys compared to the control group who engaged in more representational play events, such as combing hair or stirring a pot.

Preventive and Public Health Efforts

Dr. Howard suggests that rather than incarcerating drug-abusing parents, courts should mandate health care for the drug-exposed child (North American Council on Adoptable Children, 1990). National child welfare policies that address the needs of an

increasingly disenfranchised group of American families—poor people of color and their children who reside in inner cities—are imperative if we are to stem the tide of fragile children entering the system. Statistics released recently (U. S. Select Committee, 1990) attest to the need for sweeping change: One-third of all pregnant women receive insufficient prenatal care; in 1987 63 percent of Medicaid recipients and uninsured women and 69 percent of low-income teens received insufficient prenatal care; in 1987 the infant mortality rate was 10.1 per 1000 births but the rate for Black infants was 17.9 per 1000 births; a 1983 national survey of private obstetricians found that 44 percent did not accept Medicaid reimbursement. In 1989 the House Select Committee heard testimony citing that the proportion of Black women in the 1980's who received late or no prenatal care rose slightly from the 1970's and is twice as large as the proportion for white women (U.S. Select Committee, 1989b). Twelve out of 18 hospitals surveyed by the House Select Committee revealed that they have no place to send pregnant women for drug treatment; in Boston at any given time 30 slots are available for the 300 pregnant, drug-abusing women seeking treatment (U. S. Select Committee, 1989a).

The Report to the Chairman, U.S. Senate Committee on Finance (1990) outlined three basic components of prenatal care to ameliorate some of the problems and costs associated with the birth of drug-exposed infants: 1) early and continued risk assessment, 2) health promotion, and 3) medical and psychosocial interventions and follow-up (p. 9). However, questions immediately arise as to whether such prenatal care would be aimed only at low-income women of color at risk of drug-abuse, or targeted for all American women under the auspices of universal prenatal care. Stigma is implied by the former, while the later implies entitlement .

Several experts in the field of maternal health and prenatal care recently gave testimony supporting complete policy and delivery overhaul. Dr. Ezra Davidson of the Institute of Medicine's Committee to Study Outreach for Prenatal Care outlined the Institute's findings. Chief barriers to prenatal care include: 1) financial and administrative problems (private insurance restrictions, Medicaid coverage, no coverage); 2) inadequate capacity in the prenatal care system; 3) problems in the organization, practice, and atmosphere of prenatal services; 4) cultural and personal factors; and, 5) increased crack cocaine use and its effect on new mothers, infants, and neighborhoods. Davidson recommends that top priority be given to assure access to prenatal care for all pregnant women. Elimination of financial barriers is paramount; visible leadership must be taken by the President and members of Congress to assure this. A public information campaign should be mounted in the United States to educate Americans about the

importance of prenatal care. Institutional and organizational practices must assure prompt, easy clinic appointments, follow-up of missed visits, and services delivered in a culturally sensitive manner. Further institutional changes must minimize bureaucracy, link pregnant mothers with additional social supports and provide home visits by public health professionals (U. S. Select Committee, 1990).

Jennifer Howse, president-designate of the March of Dimes Birth Defects Foundation identified effective components of model prenatal care programs in New York City. One hospital offers on-site child care for clients and provides a woman with her first prenatal visit on the same day as her pregnancy test. Other hospitals are staffed by bilingual midwives, offer Saturday appointments and staggered appointments to reduce waiting, and distribute subway tokens to ease transportation problems (U. S. Select Committee, 1990).

Joan Eberly, Director of Personal Health Services in Southwestern Michigan described the Family Health Program which operated across two counties from 1979-1985. The Family Health Program integrated four previously categorical programs—Maternal and Infant Care, WIC, family planning, and EPSDT (Early Periodic Screening, Diagnosis, and Treatment)—into one single budget, single fiscal year program. Cross-trained staff became knowledgeable and efficient "generalists" and derived greater satisfaction from offering clients coordinated services. Evaluation demonstrated that the integrated Family Health Program reduced the number of client visits by improving efficiency of service delivery (U. S. Select Committee, 1990).

Lastly, prenatal care is cost-effective. If a woman at risk for a low birth-weight delivery receives earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in short- and long-term health care costs (Report to the Chairman, Committee on Finance, U.S. Senate, 1990, p. 38).

Current research supports early intervention, home visiting, and an ecological approach to serving substance-abusing women. An ecological approach recognizes that the client's physical and social environment must be considered during assessment and case planning in addition to the client's personal attributes. Chasnoff et al (1984) note that maternal and perinatal addiction programs should aim at ". . . not only helping the mothers deal with their addiction, but teach them parenting skills necessary for proper infant stimulation and subsequent development" (p. 280). Beckwith (1988) intervened with 92 at-risk families of low birth-weight, premature infants who required neonatal intensive care. Women visited at home by a pediatric nurse or an early childhood educator were more likely to remain in the study, showed more involved and respon-

sive behavior with their infants, and had more realistic expectations of their infant's development compared to a control group of women who did not receive home visiting services. Women who received no prenatal care had the highest drop out rate. The sample consisted of women who grew up in abusive, alcoholic, or disrupted families of origin. More young mothers engaged in reciprocal interactions with their infants if they received intervention, but failed to do so without intervention.

Howard & Kropenske (1990) served 20 infants of polydrug-abusing mothers in an eighteen-month program which followed an ecological model. Biological parents, extended family members, foster families, and siblings received intervention in addition to the infants. The objectives of intervention were to assess infants and their siblings developmentally, and provide health care for all children. Parents, family members, and foster families received education about fetal infant development, child health, immunizations, safety and nutrition. Social workers provided families with crisis intervention services, counseling, referral, and community services coordination. Prevention and intervention insured continuity of medical services for all infants and aided in the early detection of their neurological and developmental problems; 50 percent of the children had developmental disabilities. Families of developmentally disabled children received home-based, follow-up services. Education helped infant caretakers understand the effects of drug-exposure on infants. Siblings with previously undiagnosed problems received intervention. Finally, project staff remained constant throughout the three year period. ". . . It is important not only to provide clinical services but to provide them through an intervenor who is able to establish an ongoing, stable, nurturing, and non-threatening relationship with the subject" (Howard et al, 1989).

It is impossible for innovative programs scattered around the country to meet all the service needs of drug-affected families. In 1988, 42 percent of children who entered care in the U.S. were under six. Between 1980 and 1990 the National Census bureau estimates that young children entering the child welfare system increased by 17 percent while the adolescent population decreased 14 percent (U. S. House Select Committee, 1989a). Wulczyn et al (1989) report that between 1975 and 1986 the number of children in substitute care in Illinois held fairly constant at 13,500. In 1987-88 the number of children in substitute care swelled by 2,800. The dramatic increase of new children into the Illinois state system was entirely due to Black children entering care in numbers disproportionate to their membership in the general population. Between 1980 and 1985 the number of Black children ages birth to four entering care in Illinois rose 53 percent while the number of new Black residents in Illinois increased by only nine percent. In

comparison, between 1980 and 1985 the non-Black Illinois population increased by 6.6 percent, and non-Black admissions into substitute care rose by eight percent. Between 1977 and 1988 the number of Black children ages birth to four entering substitute care more than doubled, while the number of non-Black children ages birth to four increased only modestly.

New York state reports that children ages birth to four entering foster care for the first time more than doubled between 1984 and 1988. In New York City numbers of children ages birth to four entering care tripled during the same time period. Children ages birth to four made up 52 percent of all children entering care in New York City for the first time in 1988 (Wulczyn et al, 1989).

A Call for the Return to Orphanages

The recent deluge of very young children into the system—especially children of color and medically fragile children—prompted calls for the return of orphanages. Joyce Ladner in a recent *Washington Post* editorial wrote, "What these children need is permanency, but the chances are that it will continue to be difficult to find adoptive families for these so-called high-risk youngsters. I advocate that we bring back the orphanage—not the huge, depersonalized warehouses of old, but small-scale caring institutions that can offer children, and their siblings, a place that they can count on to nurture them" (Ladner, 1989). Recently, Sally Provence, author of *Infants in Institutions* in 1962, cautiously recommended the revival of institutions under certain conditions: for medically fragile infants who require specialized care, and for healthy infants until stable, long-term living arrangements can be assured (Provence, 1989). Provence added that intensive services for biological parents should be integrated into residential care of infants with the aim of family reunification whenever possible.

The Impact of Institutions

What is the history of institutional care of children? Is there a difference between large and small institutions and their effect on children's development? Early studies by researchers documented institutions' long-term, adverse effects on children's emotional, social, and cognitive development (Goldfarb, 1945; Bowlby, 1951; Provence &

Lipton, 1962; Spitz, 1965). Children exhibited retarded language development, poor concentration, attention-seeking behavior that hindered social maturity, and an inability to form emotional relationships with others. Children reared in large institutions scored significantly lower on intelligence tests than other children. Beginning in 1957, Provence and Lipton followed 75 children who resided in a large, clean, dormitory-style institution from the time they were four days old up to age six. During the day shift one attendant took care of seven to nine infants; the remaining 16 hour shift was staffed by one attendant who took care of 25-30 infants. Infants were fed with bottles propped up in their cribs. Provence commented on the quiet, tranquility and blandness of the institution. An infant reared by its mother or a permanent caregiver learns that its distress signal predictably brings comfort; thus the infant develops a sense of trust and the ability to wait. Provence noted that institutionally reared infants do not develop a sense of control, trust, or prediction, nor do they learn that they have a give and take relationship with the environment. At six to twelve months institutionalized infants made minimal attempts to initiate social contact with staff; by 12-24 months toddlers had given up efforts to socially interact altogether. Institutionally reared children failed to turn to an adult for help in solving problems and they did not seek out an adult when hurt or distressed. Provence described that institutionalized infants felt like "sawdust dolls" when held—somewhat stiff and unpliable—because they were unaccustomed to being cuddled.

Spitz (1965) described the symptoms of "hospitalism" in institutionalized children deprived of reciprocal and dependable relationships in their first year of life. Hospitalism, or total emotional deprivation, occurs when separation from a constant caregiver or mother exceeds five months: motor retardation, complete passivity, vacuous facial expression, defective eye coordination and the inability to turn over comprise this state. Spitz noted that by the end of the second year institutionalized children had trouble sitting, standing, walking, and talking, and that their developmental quotient was 45 percent that of non-institutionalized children.

More recent studies examine smaller institutions for children. Barbara Tizard (1975) studied small residential nurseries that were the result of child care deinstitutionalization efforts in England in the 1960's and 70's. Fifteen to 25 children lived in residential nurseries which were divided into small, mixed age "family" groups of six children each attended by two staff. The children's regime emphasized personalized care and intellectual stimulation. Despite multiple caretakers (no male caretakers) and the absence of close relationships, children aged two to five developed average and

above average language skills. The author points out that institutions that differ in their hierarchical social organization and level of staff autonomy influence language development in institutionalized children. Children's higher language scores were associated with rearing by autonomous staff who talked more to children and provided children with more explanations, compared to children reared by non-autonomous, highly supervised staff.

Tizard & Rees (1975) compared 26 four and one half year old children who had lived in a small, well-staffed residence since infancy to a group of 39 London working class children and a group of 39 children who were adopted or restored to their natural mothers after two to four years in an institution. Institutionalized children had different but no more frequent problems compared to the London control group. Tizard and Rees pointed out that anti-social and other forms of maladaptive behavior often found in institutionalized children were not related to institutional care specifically, but to the poor quality of care in some institutions, and in some cases, children's later contact with their disturbed families. However, the study concludes that despite great improvements in residential care of children, institutional settings fail to provide children with long-term, stable, affectionate relationships that are essential to later social relations.

Tizard & Hodges (1978) followed 65 of the institutionalized and formerly institutionalized children studied in 1975 to discern developmental outcomes among the children upon reaching school age. A similar group of working-class, non-institutionalized children comprised the comparison sample. The study discovered significant differences between institutionalized and ex-institutionalized groups and their comparisons on total problem behaviors and anti-social scores. Deviations included restless behavior, poor peer relations, disciplinary problems and disruptive attention-seeking behavior among institutionalized and ex-institutionalized children. Some children still showed effects of early institutionalized rearing up to six years after leaving the institution. Institutionalized and ex-institutionalized children more often had problems at school than their counterparts adopted in infancy.

In the most recent follow-up of ex-institutionalized children Hodges and Tizard found that ". . . children who had spent at least the first two years of their life in residential care were likely at age 16 to have more social and emotional problems than other children, and more disruptions in their lives" (1989a, p. 69). At this age, adolescents showed more problems at school than at home. In fact, many ex-institutionalized adolescents had good attachments to their adoptive parents, demonstrating that some children who are deprived of consistent, nurturing relationships early in life can make

such attachments later. In contrast, many ex-institutionalized children who were restored to their birth parents exhibited problems both at home and at school. Hodges and Tizard hypothesize that birth parents and adoptive parents differed in how much they wanted the child and how much time and effort they were able to put into the parent-child relationship. Birth parents often had fewer resources, more other children, and higher ambivalence about reunification compared to adoptive parents who very much wanted a child and devoted effort to building a relationship with the adopted child. Hodges and Tizard state that the ". . . prime aim should be to keep children in a family where they are wanted" (p. 69). Yet despite these attachments, certain differences and difficulties in social relationships are found over 12 years after a child has [left an institution and] joined a family" (1989b, p. 96).

The majority of research on long-term childhood institutionalization, involving multiple caretakers has been shown to lead to important social deficits and problems in interpersonal relationships (Berry, 1975; Quinton, Rutter, and Liddle, 1984; Rutter, 1981; & Wolkind, 1974). Erickson et al (1985) refers to:

> ". . . striking evidence for the importance of secure attachment to a child's competent functioning in subsequent years. Children securely attached as infants were found to be more ego resilient, independent, compliant, empathic, and socially competent; they had greater self-esteem and expressed more positive affect and less negative affect than did children who were anxiously attached as infants . . . quality of attachment at 12 and 18 months is a strong predictor of behavior in the preschool at age four-and-one-half and five" (p.149).

Perhaps some of the most striking research is on the long-term effects of institutionalization on psychosocial functioning and parenting of 81 adult women who were institutionalized before the age of five (Quinton, Rutter, & Liddle, 1984). Ninety percent spent at least four years in a residential nursery. [These were the same residences and some of the same children studied by Tizard in the 1970's.] The comparison group was a quasi-random sample of 41 women never admitted into care. Results reveal that institutionally-reared women showed a higher rate of poor psychosocial functioning and severe parenting difficulties in adult life. Twenty-five percent exhibited a personality disorder compared to none of the control group. Serious failures in parenting (children removed from the home or transient or permanent parenting breakdown) were evident only in the institutionally-reared sample. Early institutionalization predisposed women to experience poor social circumstances (living in a dwelling without a kitchen,

toilet, bathroom, or telephone, or over-crowded living situation). "Only a minority of women with a stable harmonious pattern of upbringing exhibited poor parenting when subjected to chronic stress and disadvantage in adult life, but the majority of those who lacked good rearing in childhood did so." Institutionalization appeared to leave women ". . . less well prepared to deal with adult adversities" (p. 122).

Teenagers with a history of multiple placements continue to comprise a substantial proportion of out-of-home placements nationally. However, numbers of adolescents institutionalized due to foster care breakdown is overestimated according to a recent study by Colton (1988). Colton's study compares care practices in treatment foster and congregate care settings for adolescents. Foster care breakdown preceded institutionalization for only 13 percent of adolescents in one study cited by Colton. One might assume that institutionalized adolescents would exhibit more behavior problems and disruption compared with adolescents living in treatment foster care. However, no behavioral differences existed between institutionalized adolescents and fostered adolescents; on the contrary, fostered adolescents seemed to have more traumatic pasts. Random luck seemed to be the deciding factor when placing adolescents in treatment foster care or in institutions. Predictably, treatment foster homes were found to be more "child-oriented" compared to institutions which were more "institutionally-oriented." In treatment foster care adolescents had their own wardrobe (versus shared clothing in institutions), and decorated their bedrooms and displayed personal belongings in their foster home bedrooms. Decorations, posters, and personal effects were not in evidence in adolescents' institutional rooms.

Staff in institutions tended to use more inappropriate or ineffective methods of control compared to treatment foster parents who displayed more effective methods of controlling adolescents. Inappropriate methods included public disapproval, threatening to discharge the adolescent, and limiting the adolescent's access to the outside world. In contrast, foster parents used rewards, sanctions, encouragement and voiced disappointment to gain an adolescent's compliance. Disapproving and controlling speech comprised the greater proportion of directives given by institutional staff, whereas foster parents used informative speech containing "approving" language. Fostered adolescents participated in household rule-making and chores while institutionalized adolescents did not.

While the kitchen and living room were the focus of household interaction in treatment foster homes, the office absorbed the majority of institutional staff's attention. Staff-resident discussions were of shorter duration than those of foster parents and

fostered adolescents. Familiarity, reciprocity, and social closeness existed between foster parents and adolescents but was notably absent in staff-resident relationships. Fostered adolescents behaved in more socially acceptable ways towards their foster parents, while institutionalized adolescents interacted more deviantly with staff members. Finally, while it is possible for both institutionalized and fostered adolescents to show improvement in areas of physical violence, school truancy, court appearances, and educational performance, gains can be made in similar adolescent populations without resorting to institutional care.

A number of researchers compared the developmental outcomes of children reared in institutions with those reared in foster care and adoption. Roy (1983) found increased rates of inattention and poorly modulated social behavior and task performance among children reared in institutions. Berry (1975) found higher levels of psychiatric referral and current problems in personal and social adjustment among institutionally reared children compared with foster and adoptive children. Prolonged institutionalization in early life was the factor most likely to lead to foster care failure in Trassler's (1960) study of children in foster care.

A study by Triseliotis and Hill (1990) of 124 adults reared in adoptive, foster, and residential care reveals that "those who were adopted and, to a somewhat lesser extent, those formerly fostered experienced more intimate, consistent, caring, and closer attachments to their caregivers compared with those who grew up in residential establishments" (p. 111). "Both the adoption and foster care sample, but particularly the former, demonstrated that the impact of early adverse experience can 'fade away' with the opportunity to form new positive attachments" (p. 115).

Alternative Models of Care

A return to orphanages is in clear violation of Public Law 96-272, the federal Adoption Assistance and Child Welfare Act of 1980 which seeks to provide permanent homes for children caught in the child welfare system, either through reunification with their biological family or placement for adoption. A plethora of less restrictive options exist to institutionalization. Treatment foster care is far less restrictive and less expensive than institutionalization or residential care. Model programs exist that utilize intensive case management for biological parents, recruitment of foster-adoptive parents, and state programs that train specialized foster parents and license "non-traditional" foster

families.

Stroul (1989) states that, "Given society's belief that family life is the best environment for a child, therapeutic foster care asserts that emotionally disturbed children should not be denied the experience of family and community life by virtue of their specialized treatment needs" (p. 18). Nor should infants and small children--free from emotional disturbance but affected by drug exposure--be denied the chance to bond with consistent and loving parents. In a national survey of 48 treatment foster care agencies conducted by Snodgrass and Bryant (1989), the majority were operated by voluntary, non-profit agencies. Twenty-five percent were operated by public agencies. Features of treatment foster care often include: intensive work with each child and foster family, individualized case plans for children, training and other supports for foster families, small caseloads for staff working with foster families, and an immediate staff response to crisis (Friedman, 1989).

The New Jersey Department of Human Services, Division of Youth and Family Services (DYFS) teaches specially recruited foster families how to care for medically fragile children. The Special Home Services Provider Program emerged as a response to the alarming rise in the number of infants with severe medical problems, including AIDS infection and crack addiction, whose families were unable to care for them (State of New Jersey, 1989). In a survey of area hospitals DYFS found that almost half the babies awaiting placement were born drug-addicted. In a nine month period in 1989, 71 percent of 603 infant referrals to DYFS needed specialized care. Sixty-five percent of that number were substance addicted, 26 percent had other medical conditions, and nine percent were HIV positive (State of New Jersey, 1989). Reflecting the dwindling number of foster homes available on a national level (Katz, 1990), New Jersey needed to seek and train substitute care providers willing to undergo intensive training and abide by certain conditions curtailing work outside the home. The Special Home Services Provider Program provides foster families with financial support that reflects the difficulty of caring for medically fragile infants and the special training it requires. Foster parents receive intensive training and counseling, in-home support services, and placement of one or two infants maximum. Foster families are paid $500 per month for three months to guarantee space availability for special needs infants. Once an infant is placed, the foster family receives $900-$1200 depending on the severity of the child's medical needs. The Special Home Services Provider Program emphasizes the need for a consistent primary caregiver; in two parent families only one parent may work outside the home. In a single parent family the caregiver may work only ten hours a week

outside the home.

In the Detroit area, the Judson Center in Royal Oak, Michigan sponsors the L.I.F.E. Program. L.I.F.E. (Living in Family Environments) recruits, trains, pays, and takes eligible families off public assistance to care for special needs foster children. Placed children are older children, ages 10-18, physically handicapped, and/or severely and profoundly retarded who would otherwise live in institutions. The L.I.F.E. program counters the argument that creating a dependent relationship between two disenfranchised groups (welfare families and handicapped children) does a disservice to both. L.I.F.E. waives the provision that families have a stable and adequate income, recognizing that many local welfare-dependent families fell victim to regional economic and industrial shifts that caused rampant unemployment in the 1980's (Judson Center, 1986). Foster families receive $22,000 per year plus medical benefits. The average family size is 3.2 persons. Training includes instruction in developmental disabilities, home management, health and safety, nutrition, hygiene, use of community resources, and communication. Respite care is available to families, and a minimum of one hour of in-service training is required of foster families each month. While the project is small (14 families serve 14 special needs foster children), L.I.F.E. receives national attention for its two-pronged approach to special needs children and welfare recipiency.

Lutheran Social Services of Washington and Idaho reduced social work caseloads to ten children per worker, delivered intensive services to biological parents, emphasized parental visiting, and recruited foster parents who agreed to become the child's adoptive family if necessary (Katz, 1990). From the start, social workers discussed the child's need for permanency. Reunification, termination of parental rights, and adoption were simultaneously discussed with biological parents in order to reduce the length of time needed for case resolution. The average time from intake to permanency was 13 months, and 82 percent of the 39 children sampled had only one placement during the one and a half year project.

The fiscal impact of decisions concerning children's living arrangements while in foster care can be staggering. For example, in 1990 the foster care population will increase by an estimated 20,000. Using estimates from the chart that follows, if all 20,000 new children coming into care were placed in residential settings the cost to the taxpayer would be $730 million per year. If these same children were placed in some combination of family, specialized, and therapeutic foster care at an average of $25/day, the cost to the taxpayer for these children would be $182 million per year. Though the costs of caring for these children in foster homes is great, it is significantly less than

if the children were placed in institutions.

Estimated Daily Rates for Costs of Out-of-Home Care, 1990	
CATEGORIES OF CARE	**DAILY RATE**
Basic Family Foster Care	$8-15
Specialized Foster Care (Supplemental payments for care of children with physical or mental disabilities)	$15-30
LIFE Foster Home (Michigan) (Does not include AFDC transfer)	$36
Therapeutic Foster Care	$40
Residential Foster Care	$100
Hospital Placement	$300

(Testimony of Joe Kroll, NACAC, before U.S. Ways and Means Committee, 1990)

Conclusion

The extent of the problems are new and the solutions are tentative, however the above-mentioned literature seems to point in these directions:

The Need for Universal Public Health Services and Prenatal Care:

1. All women should have access to public health services and prenatal care. Public leaders must make a commitment to this area or risk losing future generations of productive Americans to the ravages of drugs and poverty.
2. Successful programs tailor their organizational practices to meet the needs of the consumer. Saturday appointments, assistance with transportation, child care, and increased cultural sensitivity (e.g., bi-lingual staff), characterized successful programs.
3. Programs with an ecological approach identify both the client and the client's family as recipients of services to be delivered in the client's home and neighborhood. Home visiting by professionals yields favorable outcomes for mother and child.
4. Integration of key services can only be accomplished by scrapping the present categorical delivery of WIC, Maternal and Infant Care, family planning and EPSDT services and blending programs to efficiently meet the needs of consumers.

Institutions Fail to Nurture Children:

Fifty years of research reconfirms the same findings: long-term institutionalization in early childhood leads to recurrent problems in interpersonal relationships, high rates of personality disorders, and severe parenting difficulties later in life. Even a small residential facility is ultimately a public institution, and we know the state to be a poor parent.

Alternative Models of Child Welfare Practice:

1. More intensive and longer lasting services to children at home are needed to maintain families in times of stress (Barth & Berry, 1990).
2. Vigorous foster family recruitment should focus on families who are willing to become the child's adoptive family if reunification fails.
3. Case management practice should use a two-pronged approach in which reunification, termination of parental rights, and adoption are discussed simultaneously with biological parents in order to resolve the question of permanency in a timely manner.
4. Non-traditional families (e.g., single-parent families, families who receive public assistance and others) should be recruited and specially trained to care for medically fragile children. Remuneration should be commensurate with the conditions of fostering special needs children and the training it requires.

Finally, a comprehensive approach to treating high-risk children will be implemented on a large scale only if legislators and the public dedicate robust support to this end. We must answer the question: How much do we value our future generation?

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THE NORTH AMERICAN COUNCIL ON ADOPTABLE CHILDREN

WHO WE ARE:
The North American Council on Adoptable Children (NACAC) is a nonprofit, broad-based coalition of volunteer adoptive parent support and citizen advocacy groups, caring individuals, and agencies committed to meeting the needs of waiting children in the United States and Canada.

WHAT WE DO:
Activities include:
- a quarterly newsletter called *Adoptalk*, devoted to current issues in adoption, foster care, parenting, and child advocacy
- the largest national conference on adoption issues, uniting the concerns and resources of over 1000 experienced adoptive parents, child welfare professionals, and advocates annually
- adoptive parent group development and assistance to a network of over 500 local organizations throughout the United States and Canada working to provide public awareness of adoption issues, family support programs, administrative monitoring, and recruitment of prospective parents
- adoptive family recruitment initiatives generally and in targeted communities
- public education, special events, and Adoption Awareness Month across the United States and Canada
- post-legal adoption service models, including a peer-counseling approach
- research and publications on current critical issues in special needs adoption
- strong, consistent, directed advocacy on behalf of children and families, including federal testimony on parental leave, medically fragile infants, post-legal adoption service needs, subsidy, and recruitment of minority parents for waiting minority children

OUR AGENDA:
We believe the goal of permanence for all children is realistic, cost-effective, and clearly in their best interest. Collectively, as concerned citizens, parents, decision makers, and advocates, our impact and ability to effect change for vulnerable children is dramatic. Together we can make a difference.

TO JOIN WITH US:
NACAC is a membership organization that needs your support. Individual and parent group memberships are $25 annually. Organizational membership is $100. Additional contributions are also welcome and needed. For further information on benefits of membership or to join with us on behalf of special needs children, contact NACAC, 1821 University Avenue, Suite N498, St. Paul, Minnesota 55104; 612-644-3036.